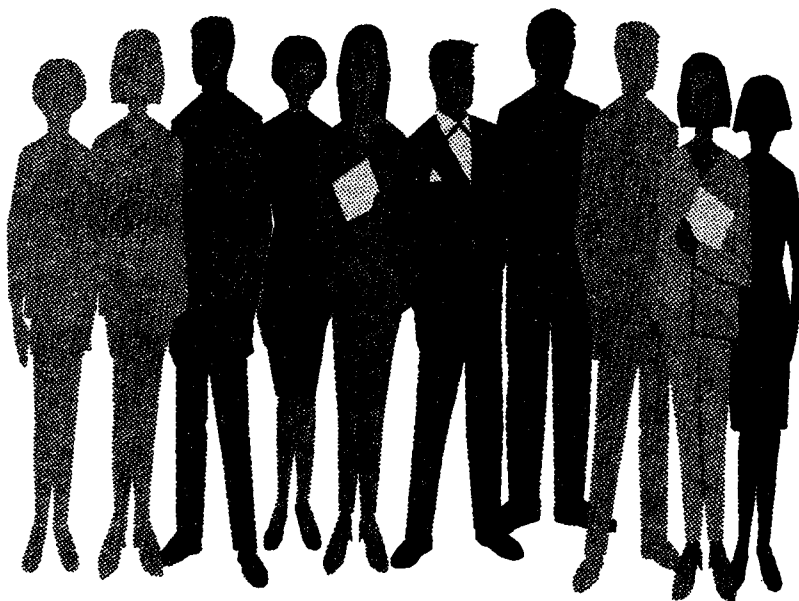




# MOBILIZATION INSURANCE PROGRAM

FOR THE READY RESERVE



Ready Reserve Mobilization Income Insurance  
Program



COMDTPUB 1341.1





COMDTPUB 1341.1

DEC 6 1996

COMMANDANT PUBLICATION 1341.1

Subj: MOBILIZATION INSURANCE PROGRAM FOR THE READY RESERVE

1. **PURPOSE.** This publication explains the Ready Reserve Mobilization Income Insurance Program (RRMIIP) to eligible members of the Coast Guard Ready Reserve.
2. **ACTION.** Area and District Commander, Commanders of Maintenance and Logistics Commands, Commanding Officers of Headquarters Units, and Commander, Coast Guard MIO Europe shall ensure compliance with this publication.
3. **DIRECTIVES AFFECTED.** Supporting Coast Guard directives are Commandant Instruction M1001.28, Reserve Policy Manual and PPCINST M1000.2, Personnel and Pay Procedures Manual. The Coast Guard version of RRMIIP is derived from Department of Defense Instruction 1341.10, "Ready Reserve Mobilization Income Insurance Program (RRMIIP) Procedures."
4. **FORMS/REPORTS.** In accordance with COMDTNOTE 5600, Directive, Publication and Reports Index (DPRI), this publication may be ordered from the Department of Transportation/Subsequent Distribution Office (USCG Stock)/Ardmore East Business Center/3341 Q 75<sup>th</sup> Avenue/Landover, MD 20785. The publication includes DD Form 2746, "Ready Reserve Mobilization Income Insurance Certificate and a reproducible copy of the required DFAS-CL Form 1241/1, "Ready Reserve Mobilization Income Insurance Program (RRMIIP) Payment Authorization." In addition to COMDTPUB 1341.1, the Standard Workstation III will have DD Form 2746 and DFAS-CL Form 1241/1 available in the Forms Filler Program effective 1 February 1997.

R. M. LARRABEE

Director of Reserve and Training

DISTRIBUTION - SDL No. 134

	a	b	c	d	e	f	g	h	i	j	k	l	m	n	o	p	q	r	s	t	u	v	w	x	y	z
A	5	5	5		5	5	5	5	5	5		5	5	5	5	5	5	5	5		5					
B	10*	5	5	2	5	5	2	20	5	5	2	2	5	20	3	2	5	5	5	5	2	3	5	5	2	5
C	5	5	5	5	5	5	5	2	5	5	5	5	5	2	5		5	2	2	20	5	5	5	5	2	
D	5	5	2	5	5	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2
E	5	20	2				2	2		2	2	2		5	3		2		5	3		2	2			
F																	1									
G	5	2																								
H																										

NON-STANDARD DISTRIBUTION: \*Ba: HSC (A-1)





1341  
03 SEP 1996

From: Commandant  
To: All Ready Reservists

Subj: READY RESERVE MOBILIZATION INCOME INSURANCE PROGRAM

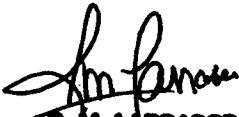
1. I am pleased to announce a new benefit that will soon be available to all members of the Ready Reserve who are not in an active duty status. The new benefit, known as the Ready Reserve Mobilization Income Insurance Program (RRMIIP), is a provision of the 1996 Defense Authorization Act and it will take effect 1 October 1996.
2. This program of insurance is designed to help you and your family avoid significant financial consequences when you are called to active duty and lose income due to the difference between your active duty military pay and civilian income. Benefits will be paid to participating members involuntarily ordered to active duty for 31 days or more under the recall authority of Title 10, U.S. Code (coverage for involuntary recalls for domestic emergencies is not included). Participants in the program will be eligible for coverage ranging from \$500 to the current maximum of \$5000 per month. Benefits will be paid from premiums that have been paid into the program by participants. The premium rate is \$12.20 for each \$1000 worth of coverage while the premium rate for each \$500 increment of coverage is set at one-half of that amount. For example, the monthly cost for \$1500 worth of coverage would be  $1.5 \times \$12.20$  or \$18.30; the quarterly cost would be  $1.5 \times 3 \times \$12.20$  or \$54.90.
3. Remember, premiums must be paid in advance. Therefore, unless you are signing up for "Auto Pay" from your bank account, you must submit a check, payable to "DFAS - Cleveland Center," for the first quarterly premium amount with your enrollment certificate. Your enrollment package must be returned in the enclosed pre-addressed envelope to your servicing PERSRU.
4. Let me emphasize that this is a voluntary program and it will be your choice to participate. As the law is currently written, there is normally only one opportunity to elect to participate in this program. Therefore, it is important that you give careful consideration to your decision to participate – or not to participate. If you are a member of the Selected Reserve and you decide to decline coverage when it is first made available to you, that law as currently written does not give you the option of enrolling at a later date. We recognize that this is a very significant constraint and we will consider having the law amended to provide more flexibility at a future date, if such action is appropriate. However, your current decision is subject to the law as it is now written.

Subj: READY RESERVE MOBILIZATION INCOME INSURANCE PROGRAM

5. The following information will assist you in making your decision:

- a. A fact sheet containing answers to questions about this insurance program, enclosure (1).
- b. Uniform instructions to complete the insurance declaration/application, enclosure (2).
- c. An original application form with two copies is included with this package. Copies 1 and 3 must have original signatures while copy 2 is to be retained as your personal copy. Block 10, "Witnessed and Received By," will be completed after receipt by your PERSRU. The member does not have to be present.
- d. RRMIP "Payment Authorization Instructions," enclosure (3).

6. If you have any specific questions or need additional guidance, you should contact your servicing PERSRU. If your PERSRU staff cannot answer your questions, then they should contact the CGPC (rpm) at 1 (800) 283-8724. **REMEMBER! Your decision to enroll or decline coverage may be one of the most important decisions that you will make regarding your financial affairs. Please take the time to give careful consideration to this decision.**

  
**R. M. LARRABEE**  
**DIRECTOR OF RESERVE AND TRAINING**

Encl: (1) RRMIP Information Packet  
(2) RRMIP Declaration/Application Instructions  
(3) RRMIP Payment Authorization Instructions

Copy: CGPC (rpm)  
CGPPC  
All ISC (pf)

## INFORMATION PROVIDED ON MOBILIZATION INSURANCE FOR RESERVISTS

With the signing of the FY 96 National Defense Authorization Act on February 10, 1996, members of the National Guard and Reserve gained the ability to protect their civilian income from losses accrued by federal military service. Since that time, the Department of Defense has been getting a great many questions on this new provision in the law called the Ready Reserve Mobilization Income Insurance Program.

Effective September 30, 1996, the law provides that members of the Ready Reserve ordered involuntarily to active duty (other than for training) for more than 30 days are eligible to participate in an optional program of income insurance. The order must specify that the member's service is in support of war, national emergency, or to augment active forces for an operational mission, as provided by law.

With this new benefit, participating Ready Reservists can have peace of mind knowing that benefit payments will continue for up to one year, or a maximum of 12 months out of any 18-month period. Thus, their military earnings can be supplemented to compensate for some of the difference between their military and civilian pay.

The new program was prompted by our experience in the Persian Gulf War. A survey of Reserve component members after the conflict revealed that approximately two-thirds of the nearly 250,000 Reservists activated during Operation Desert Shield/Storm suffered economic loss as a result of:

- Military pay being less than civilian income (to include Reserve duty pay);
- Additional expenses incurred by the member and his/her family as a result of activation; and
- Continuing losses after release from active duty due to erosion of a civilian business or professional practice.

Losses were widespread across all pay grades and military occupations. Approximately two-thirds of the enlisted members and more than one-half of the officers surveyed indicated that they would buy income insurance.

**A DoD Instruction which details policy and procedures is being distributed however, financial management guidelines are still being finalized.** Attached are the most frequently asked questions and answers to date.

**ENCLOSURE(1)**

## **QUESTIONS & ANSWERS CONCERNING THE READY RESERVE MOBILIZATION INCOME INSURANCE PROGRAM**

### **Q1: What are the basic features of the Ready Reserve Mobilization Income Insurance Program and how will it work?**

It is an optional program of income insurance. Traditional members of the Ready Reserve and National Guard, including Coast Guard Reservists, are eligible to collect payments if they are recalled to active military duty (other than for training) for a period of more than 30 days. Member's orders must specify that the member's service is involuntary and, that the duty is in support of an operational mission for which RC members have been ordered to active duty without their consent or is service in support of forces activated during a period of war or of national emergency declared by the President or the Congress. The basic coverage starts at \$1,000 per month, with incremental increases of \$500 up to the current maximum of \$5,000 per month. Benefit payments can be received for up to one year, or a maximum of 12 months during any 18-month calendar period.

### **Q2. Who is eligible to enroll in the Ready Reserve Mobilization Income Insurance Program?**

Eligibility is open to members of the Ready Reserve, with the exception of those Reserve and National Guard members who are on active military duty, i.e., AGRs/TARs/full-time National Guard, etc. The Ready Reserve is comprised of Reserve and National Guard units and/or individuals, who can be called to active duty in time of war, national emergency, or to augment active forces for an operational mission as provided by law.

### **Q3: How much will this insurance cost?**

The premium rate, approved by the Secretary of Defense is \$12.20 per \$1,000 in coverage.

### **Q4. How can I enroll in the Ready Reserve Mobilization Income Insurance Program?**

On and after the date the program is implemented, in October 1996, members of the Ready Reserve will have an opportunity to decide if they want to participate in the program. Effective October 1, 1996, new members of the Ready Reserve will automatically be insured at the basic benefit level of \$1,000/month of coverage and, within 60 days will have to choose from three options:

- Increase desired coverage. (It can be increased in \$500/month increments to the current maximum benefit of \$5,000/month.)
- Decrease desired coverage from the automatic \$1,000/month to \$500/month.
- Decline coverage.

A member of the Ready Reserve, as of September 30, 1996, will receive written notification that the program is effective October 1, 1996. The member will have 60 days from notification to choose between the same three options. In either case, members (new or existing) shall be considered as having declined to be insured if they fail to complete the enrollment process within the 60 day election period.

**Q5. I decline to accept coverage now. Can I elect to enroll at a later date?**

Generally, no. Under current legislation, as long as an individual remains in the Ready Reserve, that member will be given only one opportunity to enroll and to select the level of coverage required to replace lost income. Exceptions will be made for:

- Personnel who separate from active duty and reenter the Ready Reserve, if they have not previously declined coverage while a member of the Selected Reserve.
- Personnel who change Military Services.
- Personnel who separate from the Ready Reserve and reaffiliate at a subsequent enlistment or appointment.
- Personnel who enter the Individual Ready Reserve directly and who subsequently transfer to the Selected Reserve as long as they have not declined coverage while previously a member of the Selected Reserve.

**Q6. How will I pay the premium?**

For the first year of program startup, monthly premiums, payable in advance, may be paid in one of two ways:

- Automatic deduction from the same bank account that is authorized to receive a Direct Deposit of monthly drill pay. This option is also available to members in a nonpay status.
- Through periodic billings i.e., quarterly for members in a nonpay status or members who do not opt for automatic deduction.

These payment options are the same for all categories of insured Reservists.

**Q7. How will the benefits be paid once I have been involuntarily activated?**

Eligibility for benefits begins at the end of the first payroll month with the first payment occurring at the end of the second payroll month of covered service. Benefits would be:

- Paid in accordance with procedures established by the Secretary of Defense;
- Subject to tax withholding.

**Q8. Will the benefits be prorated for part of a month?**

Prorated benefits will be paid for any part of a month after the first 30 days. For example: a Reservist who is involuntarily activated for 35 days with \$3,000 in coverage, would receive \$500 as an income loss replacement benefit (5 days x \$100/day), in addition to military pay and benefits for the time period.

**Q9. If I am mobilized and drawing the benefit, will I still be required to pay the premium while I am on active duty?**

Yes. It is just like any other insurance program. Premiums are continuously collected to build the fund from which benefits are paid.

**Q10. Are premium rates fixed? Is there a chance the rates could change?**

The Department of Defense Board of Actuaries will recommend premium rates to the Secretary. Utilizing standard accounting practices, the Board will review the Fund on a periodic basis. It is possible that premium rates could increase or be reduced dependent upon the financial soundness of the program.

**Q11. Will I be able to increase my coverage at a later date?**

The law does not currently provide for an increase in the schedule of benefits.

**Q12. Are benefits under the program of insurance protected from inflation?**

Yes. The Department of Defense Board of Actuaries is, under the law, required to carry out periodic actuarial valuations of benefits offered by the insurance program and recommend appropriate changes to the Secretary of Defense to reflect changes in the value of

benefits paid under the program. Should such an increase in benefit payments occur, a corresponding adjustment will be made to the premium rate to offset the effects of inflation.

**Q13. By law the insurance program is designed to be self-funded from premiums paid by insured members. What happens if assets in the Fund are insufficient to pay full benefits during the start-up phase of the Program?**

If at any time assets of the Fund are expected to be insufficient to pay the insurance benefits the Secretary of Defense will request the President to submit to the Congress a request for a special appropriation to cover the insufficiency. If such appropriation is not made, the Secretary of Defense in coordination with the DoD Actuary, will reduce the amount of benefits paid to a total amount that does not exceed the assets of the Fund by the end of the fiscal year. Benefits that cannot be paid because of such a reduction will be deferred and may be paid only after and to the extent that additional funds become available.

**Q14. As a Ready Reserve member, how should I decide how much coverage to get?**

This program is not designed to be a dollar-for-dollar replacement of lost civilian income; rather it is intended to help close the gap between civilian and military pay. As you decide on how much coverage to get, you may want to consider factors such as:

- What can my family and I live on if I am called to active duty?
- How much can I afford to pay for insurance premiums?
- What support is available to me from other sources (i.e., the Soldiers and Sailors Relief Act and the Uniformed Services Employment and Reemployment Rights Act)?
- Are there predictable lifestyle changes in the near future for which I need to plan (i.e., change of civilian employment, move to self-employment, etc.).
- Remember, a decision to decline coverage at the present time, may not be revoked without a change to the current law.

**Q15. Is this program retroactive to cover past activations for Bosnia or Haiti?**

No. As prescribed in the law, the Ready Reserve Mobilization Income Insurance Program may only be offered after its effective date of September 30, 1996.

**Q16. Does RRMIP cover mobilization for Title 14 recall?**

No. RRMIP only applies to Title 10 recall (involuntary active duty for military operations). Ready Reservists should not be concerned about these distinctions since Title 14 recall (emergency active duty for other than military operations) is limited to 30 days or less. For distinctions between Title 10 and Title 14 recall, refer to COMDTINST M1001.27A, Sec 2-A through 2-D or the source legislation for mobilization, 10 USC 12301-12304 and 14 USC 712. National Guard members face a similar situation in that all of their recalls are not under Title 10.

## READY RESERVE MOBILIZATION INCOME INSURANCE CERTIFICATE

### PRIVACY ACT STATEMENT

**AUTHORITY:** P.L. 104-106, National Defense Authorization Act for FY 1996; and E.O. 9397, "Numbering System for Federal Accounts Relating to Individual Persons."

**PRINCIPAL PURPOSE(S):** The form is used to record personal and other applicable information needed to enroll or decline enrollment in a program of insurance to protect against income loss resulting from involuntary recall to active duty (other than for training) for more than 30 days.

**ROUTINE USE(S):** None.

**DISCLOSURE:** Voluntary; however, failure to furnish requested information will result in the individual not participating in the insurance program.

## S A M P L E

### WHAT THE MEMBER SHOULD KNOW

This insurance is granted under the Ready Reserve Mobilization Income Insurance provisions of title 10 United States Code, Chapter 1214, and is subject to the provisions of that title and its amendments, and regulations promulgated thereto.

**Covered Service.** Active duty (AD) performed by a member of a Reserve component under an order to AD for a period of more than 30 days. The AD order must specify that the member's service is involuntary and in support of an operational mission; or in support of forces activated during a period of war or national emergency declared by the President or Congress.

**Entitlement to Benefits.** An insured member shall be entitled to payment of a benefit for each month (and fraction thereof) of covered service that exceeds 30 days of covered service, except that no member may be paid a benefit for more than 12 months during any period of 18 consecutive months. Proof of loss of income or expenses incurred as a result of covered service is not required.

**Insufficient Assets.** If assets are insufficient to pay benefits the Secretary will request the President to submit to Congress a request for a special appropriation to cover the insufficiency. If an appropriation is not made, the Secretary will reduce the amount of benefits paid to a total amount that does not exceed assets of the Fund by the end of the fiscal year. Benefits not paid because of such reduction will be deferred and may be paid only after and to the extent that additional funds become available.

## INSTRUCTIONS ON COMPLETING THIS FORM

1. Type or print in ink all items except where otherwise noted.

### 2. BENEFICIARY(IES)/DESIGNATED RECIPIENT(S) (B/DR(s))

A. A new election form must be completed to change your B/DR. You may name a spouse, child, parent, heir, or other person with an insurable interest (i.e., business partner, friend, etc.). In addition, you may direct that payments of benefits be deposited with a bank or other financial institution to the credit of the B/DR. If no such designation is made, and the member is deceased, upon establishment of a valid claim the amount will be payable in accordance with the laws of the State of the member's domicile.

B. If the B/DR is a married woman, use her own first and middle names. For example, use Mary Lisa Smith, instead of Mrs. John Smith.

C. A named B/DR will **NOT** be changed automatically by any event occurring after you complete this form (e.g. marriage, divorce, etc.). Your B/DR cannot be changed by, and is not affected by, any other documents, such as a divorce decree or will.

D. If you name minor children as B/DR(s), the insurance will be paid to the court-appointed guardian of the children's estate.

## SAMPLE

### 3. SOCIAL SECURITY NUMBER

Do not delay completing this form if you do not have a B/DR's Social Security number. The Social Security number helps us to locate the B/DR, but is not necessary.

### 4. SHARES TO EACH B/DR

If you name more than one B/DR, the sum of the shares must equal 100%, or the full dollar amount of your insurance.

Example:	mother	\$500		50%		1/2
	<u>father</u>	<u>\$500</u>	or	<u>50%</u>	or	<u>1/2</u>
	Total	\$1,000		100%		1

### 5. PROVISIONS FOR PAYMENT OF INSURANCE

A. If you name more than one principal B/DR and one or more predeceases you, the share(s) will be divided equally among the remaining principal B/DR(s), unless otherwise stated. If there are no surviving principal B/DR(s), the proceeds will be divided among the contingent B/DR(s).

B. If you do not name a B/DR, or if there are no surviving B/DR(s), or if you indicate that payment should be made by law, the proceeds will be paid in the following order:

1. Widow or widower.
2. Children in equal shares (the share of any deceased child will be distributed equally among the descendants of that child).
3. Parent(s) in equal shares or all to surviving parent.
4. A duly appointed executor or administrator of your estate.
5. Other next of kin.

### 6. WHAT YOUR B/DR(S) SHOULD KNOW

To establish a valid claim, your B/DR(s) should send a claim to the member's Military Service.

# READY RESERVE MOBILIZATION INCOME INSURANCE CERTIFICATE

(Please read the Privacy Act Statement and Instructions before completing this form.)

## 1. USE THIS FORM TO: (X all that apply)

- ☐ a. Name, change or update your beneficiary
- ☒ b. Increase the amount of your insurance coverage
- ☐ c. Reduce the amount of your insurance coverage
- ☐ d. Decline insurance coverage (IRREVOCABLE)

**IMPORTANT:** This form is for use by members of the Ready Reserve. This form does not apply to and cannot be used for any other Government Insurance.

2. NAME (Last) (First) (Middle)  
Doe Jane Anne

3. RANK, TITLE, OR GRADE  
Lieutenant Commander

4. SOCIAL SECURITY NUMBER  
123-45-6789

5. BRANCH OF SERVICE (Do not abbreviate)  
United States Coast Guard Reserve

6. CURRENT DUTY LOCATION  
USCG HQ 2100 Second St., SW Washington, DC 20593-0001

## 7. AMOUNT OF INSURANCE

By law, you are eligible for the basic benefit of \$1,000. If you want \$1,000 of insurance, skip to Item 8, "Beneficiary(ies)/ Designated Recipient (B/DR) and Payment Options." If you want less than \$1,000 of insurance, please mark (X) block a. below and write the amount desired and your initials. Coverage is available in the following amounts: \$500, \$1,000, \$1,500, \$2,000, \$2,500, \$3,000, \$3,500, \$4,000, \$4,500, or \$5,000. If you want additional coverage above the \$1,000 amount, mark block a. and write in the exact amount desired in \$500 increments up to the maximum amount allowable. If you do not want any insurance, mark block b. below and write (in your own handwriting), "I do not want insurance." Actual benefit amounts are subject to periodic adjustment.

☒ a. I want coverage in the amount of \$ 1,500.00 . Your initials: JAD

☐ b. (Write "I do not want insurance.")

**NOTE:** Once enrolled, you may reduce the amount or stop your participation at any time. However, you cannot increase your coverage. A decision to decline coverage or terminate your enrollment is generally irrevocable.

## 8. BENEFICIARY(IES)/DESIGNATED RECIPIENT (B/DR) AND PAYMENT OPTIONS

I designate the following person or entity to receive payment of my insurance proceeds. I understand that the principal B/DR(s) will receive payment upon my death. If a designation is not made, a valid claim will be payable in accordance with laws of the State of the member's domicile.

COMPLETE NAME (first, middle, last) OF EACH BENEFICIARY a.	ADDRESS (Street, Apartment No., City, State, and ZIP Code) b.	SOCIAL SECURITY NUMBER (if known) c.	RELATIONSHIP TO YOU d.	SHARE TO EACH BENEFICIARY (Use %, \$ amounts or fractions) e.
---	--	---	------------------------------	---

### BENEFITS WILL BE PAID TO:

(1) Jane Anne Doe	1234 1st Ave, NE Washington, DC 20593-0001	123-45-6789	Same	100%
(2) NONE	<b>SAMPLE</b>			

### PRINCIPAL B/DR

(1) Mrs. Jane Marie Doe	128 Marbury Way Savannah, GA 31410	234-56-7890	Mother	100%
(2) NONE				

## 9. I HAVE READ AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM. I ALSO UNDERSTAND THAT:

- This form cancels any prior beneficiary/designated recipient or payment instructions.
- The proceeds will be paid to B/DR(s) as stated in Paragraph 2 of the instructions, unless otherwise stated above.
- If I have legal questions about this form, I may consult with a military attorney at no expense to me.
- Maximum coverage amount available as of this date is \$ 5,000.00 . Your initials: JAD

### a. YOUR SIGNATURE (Sign in ink. Do not print.)

Jane A. Doe, LCDR, USCGR

### b. DATE

October 15, 1996

## 10. (Do not write in space below - for official use only.)

a. WITNESSED AND RECEIVED BY James T. Chief	b. RANK, TITLE, OR GRADE YNC	c. ORGANIZATION U.S. Coast Guard	d. DATE RECEIVED October 15, 1996
--	---------------------------------	-------------------------------------	--------------------------------------

## **DIRECTIONS TO PERSONNEL CLERKS OF THE MILITARY SERVICES**

1. Complete all appropriate items on the election form. All entries, except the signature and those requested to be in the member's own handwriting, must be typed or printed in ink. An original and at least one copy, which are the official copies, must bear an original signature of both the member and the witness.
2. Make sure the name(s) of one or more principal B/DR(s) appear in Item 8, "Beneficiary(ies)/Designated Recipient (B/DR) and Payment Options", if desired. Include the address and Social Security number, if available, for the B/DR(s) and their relationship to the member (e.g., father, sister).
3. An authorized agent of the Military Service must witness the signature of the member. This representative must sign his or her name below that of the member and should put the date he or she signed the form.
4. This form, properly executed, is authority to a payroll office to change the deductions for insurance premiums or to not make such deductions, if the amount of insurance is changed or cancelled.
5. Inform all members that if they have questions about this form that they may obtain the advice of a military attorney at no expense to the member.
6. Disposition of copies: Reproduce official copies before signing and circle distribution on bottom right of form. Wording and format of form may not be altered. Forms altered from the original wording or format are subject to acceptance by the Military Service.

### **S A M P L E**

Copy 1 - Must be promptly filed in the official personnel file of the member.

Copy 2 - To member. Certificate of coverage.

Copy 3 - FOR USE BY THE RESERVE COMPONENT OF THE MILITARY SERVICES

**READY RESERVE MOBILIZATION INCOME INSURANCE PROGRAM (RRMIIP)  
PAYMENT AUTHORIZATION**

***READ THE INSTRUCTIONS BEFORE COMPLETING THIS FORM.***

An AUTOPAY Election allows funds to be automatically withdrawn from your checking account to pay your monthly RRMIIP premium.

AUTOPAY is convenient and reliable. There is no need to write a premium check each month and the payment is guaranteed to be on time. AUTOPAY is very economical. You will save time and money by writing fewer checks, and spending less on postage. AUTOPAY also saves the government processing costs each month, which helps keep your premium costs lower.

Your only obligations are to ensure that there are sufficient funds in your checking account on your selected billing date (identified in Item 5) to pay your RRMIIP premium and keep the required minimum account balance. Otherwise you will be charged an insufficient funds charge by your financial institution. In addition, you will also be required to remit your premium payment by check to the address identified later in the instructions.

If you know in advance there won't be sufficient funds, you must send your RRMIIP premium to Defense Finance and Accounting Service Cleveland Center (DFAS-CL) by direct payment until your account can once again be automatically debited.

If you want to change the account number or financial institution, you need to complete a new AUTOPAY authorization and send it to DFAS-CL. There is no need to complete a new RRMIIP Certificate.

AUTOPAY Authorization will remain effective until the Defense Finance and Accounting Service (DFAS) and your financial institution receive notification from you of your desire to terminate participation. You must allow sufficient time for DFAS and your financial institution to act on your request. If you desire to terminate, you must send your request no later than the fifth of the month in which the termination is to become effective.

<b>PAYMENT AUTHORIZATION FOR THE RRMIIP</b>				<i>SEE REVERSE FOR INSTRUCTIONS.</i>																			
1. NAME (Last, First, MI)				2. SOCIAL SECURITY NUMBER <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"><tr><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td></tr></table>																			
3. HOME ADDRESS				4. HOME TELEPHONE NUMBER (       )																			
<b>ACCOUNT INFORMATION</b>																							
5. SELECTED BILLING DATE  the _____ of each month			6. ROUTING TRANSIT NUMBER <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"><tr><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td></tr></table>											7. CHECK DIGIT <table border="1" style="width: 40px; height: 20px; border-collapse: collapse;"><tr><td></td></tr></table>									
8. ACCOUNT NUMBER <table border="1" style="width: 100%; height: 20px; border-collapse: collapse;"><tr><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td><td style="width: 12.5%;"></td></tr></table>																							
9. ACCOUNT TITLE (Account Holder's Name)				10. FINANCIAL INSTITUTION NAME AND ADDRESS																			
11. COMMENTS																							
<b>AUTHORIZATION</b>																							
I hereby authorize the Defense Finance and Accounting Service to initiate debit entries to my checking account and financial institution indicated above to debit the same account. If this is a joint account, both holders must sign below.																							
12. SIGNATURE(S)						13. DATE																	

# READY RESERVE MOBILIZATION INCOME INSURANCE PROGRAM (RRMIIP) PAYMENT AUTHORIZATION INSTRUCTIONS

## PRIVACY ACT STATEMENT

Collection of the information you are requested to provide on this form is authorized under 31 CFR 209 and/or 210. The information is confidential and is needed to process payment data from the financial institution and its agent to the federal agency.

## INSTRUCTIONS FOR PREPARING AND MAILING AUTHORIZATION

**PURPOSE** - You may use the authorization form to provide information needed to deduct RRMIIP monthly premiums from your checking account. Selected Reserve and Individual Ready Reserve can either use monthly AUTOPAY or quarterly direct billing. If you are in either of these statuses and choose to elect direct billing, you must write in COMMENTS (Item 11) — "I ELECT DIRECT BILLING." Attach a check for the first three months of coverage made payable to DFAS-CL. Submit the RRMIIP Insurance Certificate and this form along with a check (applicable only to quarterly direct billing) using the enclosed envelope.

**RECIPIENT INFORMATION** - Always complete Items 1-4.

### ACCOUNT INFORMATION

**ROUTING TRANSIT NUMBER** - Item 6 - Your financial institution's 8-digit routing transit number. See the illustration below.

**CHECK DIGIT** - Item 7 - One position check digit. See the illustration below.

**ACCOUNT NUMBER** - Item 8 - Your account number at your financial institution. See the illustration below.

**ACCOUNT TITLE** - Item 9 - The depositor's name on the account at the financial institution. See the illustration below.

**FINANCIAL INSTITUTION NAME** - Item 10 - The name of the institution to which payments are to be directed. See the illustration below.

The illustration shows a check with the following fields and labels:

- 9**: NAME OF DEPOSITOR, STREET ADDRESS, CITY, STATE, ZIP CODE
- 101**: PAY TO THE ORDER OF
- 19**: \$ (Amount)
- DOLLARS**: (Amount)
- 10**: NAME OF YOUR BANK, Payable Through Another Bank, For
- 6**: 99999999 (Routing Transit Number)
- 7**: 9 (Check Digit)
- 8**: 000 000 000 (Account Number)
- CHECK NUMBER**: 010 (Check Number)

- 5 - BILLING DATE - The date each month your checking account will be debited for the RRMIIP premium.
- 6 & 7 - ROUTING TRANSIT NUMBER / CHECK DIGIT - Examine your deposit slip or check for items labeled 5 and 6 in the above sample. Are the Routing Transit Number (RTN) and Check Digit nine numbers in a row? Is the first number of the RTN "0," "1," "2," or "3"? If the answer to both questions is "yes," enter the numbers from your deposit slip or check on the attached authorization form in Items 5 and 6. Otherwise, call your financial institution and ask them to provide you with their RTN and Check Digit.
- 8 - ACCOUNT NUMBER - Include dashes where the symbol " " appears on your check. Be sure not to include the check number (#101 in the example) as part of your Account Number in Item 8. If you cannot determine your Account Number, contact your financial institution.
- 9 - ACCOUNT TITLE - Must include recipient's name.
- 10 - FINANCIAL INSTITUTION NAME AND ADDRESS - If your check or sharedraft includes "Payable Through" under the bank name, contact the financial institution to help obtain the correct Routing Transit Number for Direct Deposit.

**AUTHORIZATION** - Sign and date the request form (Items 12 and 13) after you have carefully read the instructions and Privacy Act Statement.

## READY RESERVE MOBILIZATION INCOME INSURANCE CERTIFICATE

### PRIVACY ACT STATEMENT

**AUTHORITY:** P.L. 104-106, National Defense Authorization Act for FY 1996; and E.O. 9397, "Numbering System for Federal Accounts Relating to Individual Persons."

**PRINCIPAL PURPOSE(S):** The form is used to record personal and other applicable information needed to enroll or decline enrollment in a program of insurance to protect against income loss resulting from involuntary recall to active duty (other than for training) for more than 30 days.

**ROUTINE USE(S):** None.

**DISCLOSURE:** Voluntary; however, failure to furnish requested information will result in the individual not participating in the insurance program.

### WHAT THE MEMBER SHOULD KNOW

This insurance is granted under the Ready Reserve Mobilization Income Insurance provisions of title 10 United States Code, Chapter 1214, and is subject to the provisions of that title and its amendments, and regulations promulgated thereto.

**Covered Service.** Active duty (AD) performed by a member of a Reserve component under an order to AD for a period of more than 30 days. The AD order must specify that the member's service is involuntary and in support of an operational mission; or in support of forces activated during a period of war or national emergency declared by the President or Congress.

**Entitlement to Benefits.** An insured member shall be entitled to payment of a benefit for each month (and fraction thereof) of covered service that exceeds 30 days of covered service, except that no member may be paid a benefit for more than 12 months during any period of 18 consecutive months. Proof of loss of income or expenses incurred as a result of covered service is not required.

**Insufficient Assets.** If assets are insufficient to pay benefits the Secretary will request the President to submit to Congress a request for a special appropriation to cover the insufficiency. If an appropriation is not made, the Secretary will reduce the amount of benefits paid to a total amount that does not exceed assets of the Fund by the end of the fiscal year. Benefits not paid because of such reduction will be deferred and may be paid only after and to the extent that additional funds become available.

## INSTRUCTIONS ON COMPLETING THIS FORM

1. Type or print in ink all items except where otherwise noted.

### 2. BENEFICIARY(IES)/DESIGNATED RECIPIENT(S) (B/DR(s))

A. A new election form must be completed to change your B/DR. You may name a spouse, child, parent, heir, or other person with an insurable interest (i.e., business partner, friend, etc.). In addition, you may direct that payments of benefits be deposited with a bank or other financial institution to the credit of the B/DR. If no such designation is made, and the member is deceased, upon establishment of a valid claim the amount will be payable in accordance with the laws of the State of the member's domicile.

B. If the B/DR is a married woman, use her own first and middle names. For example, use Mary Lisa Smith, instead of Mrs. John Smith.

C. A named B/DR will **NOT** be changed automatically by any event occurring after you complete this form (e.g. marriage, divorce, etc.). Your B/DR cannot be changed by, and is not affected by, any other documents, such as a divorce decree or will.

D. If you name minor children as B/DR(s), the insurance will be paid to the court-appointed guardian of the children's estate.

### 3. SOCIAL SECURITY NUMBER

Do not delay completing this form if you do not have a B/DR's Social Security number. The Social Security number helps us to locate the B/DR, but is not necessary.

### 4. SHARES TO EACH B/DR

If you name more than one B/DR, the sum of the shares must equal 100%, or the full dollar amount of your insurance.

Example:	mother	\$500	50%	1/2
	father	\$500	or 50%	or 1/2
	Total	\$1,000	100%	1

### 5. PROVISIONS FOR PAYMENT OF INSURANCE

A. If you name more than one principal B/DR and one or more predeceases you, the share(s) will be divided equally among the remaining principal B/DR(s), unless otherwise stated. If there are no surviving principal B/DR(s), the proceeds will be divided among the contingent B/DR(s).

B. If you do not name a B/DR, or if there are no surviving B/DR(s), or if you indicate that payment should be made by law, the proceeds will be paid in the following order:

1. Widow or widower.
2. Children in equal shares (the share of any deceased child will be distributed equally among the descendants of that child).
3. Parent(s) in equal shares or all to surviving parent.
4. A duly appointed executor or administrator of your estate.
5. Other next of kin.

### 6. WHAT YOUR B/DR(S) SHOULD KNOW

To establish a valid claim, your B/DR(s) should send a claim to the member's Military Service.

# READY RESERVE MOBILIZATION INCOME INSURANCE CERTIFICATE

(Please read the Privacy Act Statement and Instructions before completing this form.)

<b>1. USE THIS FORM TO:</b> ( <i>X all that apply</i> ) <input type="checkbox"/> a. Name, change or update your beneficiary <input type="checkbox"/> b. Increase the amount of your insurance coverage <input type="checkbox"/> c. Reduce the amount of your insurance coverage <input type="checkbox"/> d. Decline insurance coverage ( <b>IRREVOCABLE</b> )		<b>IMPORTANT:</b> This form is for use by members of the Ready Reserve. This form does not apply to and cannot be used for any other Government Insurance.	
<b>2. NAME</b> ( <i>Last</i> )      ( <i>First</i> )      ( <i>Middle</i> )		<b>3. RANK, TITLE, OR GRADE</b>	<b>4. SOCIAL SECURITY NUMBER</b>
<b>5. BRANCH OF SERVICE</b> ( <i>Do not abbreviate</i> )		<b>6. CURRENT DUTY LOCATION</b>	
<b>7. AMOUNT OF INSURANCE</b> By law, you are eligible for the basic benefit of \$1,000. If you want \$1,000 of insurance, skip to Item 8, "Beneficiary(ies)/ Designated Recipient (B/DR) and Payment Options." <i>If you want less than \$1,000 of insurance</i> , please mark (X) block a. below and write the amount desired and your initials. Coverage is available in the following amounts: \$500, \$1,000, \$1,500, \$2,000, \$2,500, \$3,000, \$3,500, \$4,000, \$4,500, or \$5,000. <i>If you want additional coverage</i> above the \$1,000 amount, mark block a. and write in the exact amount desired in \$500 increments up to the maximum amount allowable. <i>If you do not want any insurance</i> , mark block b. below and write (in your own handwriting), "I do not want insurance." Actual benefit amounts are subject to periodic adjustment.			
a. I want coverage in the amount of \$ _____. Your initials: _____			
b. ( <i>Write "I do not want insurance."</i> )			
<b>NOTE:</b> Once enrolled, you may reduce the amount or stop your participation at any time. However, you cannot increase your coverage. A decision to decline coverage or terminate your enrollment is generally irrevocable.			
<b>8. BENEFICIARY(IES)/DESIGNATED RECIPIENT (B/DR) AND PAYMENT OPTIONS</b> I designate the following person or entity to receive payment of my insurance proceeds. I understand that the principal B/DR(s) will receive payment upon my death. If a designation is not made, a valid claim will be payable in accordance with laws of the State of the member's domicile.			
<b>COMPLETE NAME</b> <i>(first, middle, last)</i> <b>OF EACH BENEFICIARY</b> <b>a.</b>	<b>ADDRESS</b> <i>(Street, Apartment No., City, State, and ZIP Code)</i> <b>b.</b>	<b>SOCIAL SECURITY NUMBER</b> <i>(if known)</i> <b>c.</b>	<b>RELATIONSHIP TO YOU</b> <b>d.</b>
<b>SHARE TO EACH BENEFICIARY</b> <i>(Use %, \$ amounts or fractions)</i> <b>e.</b>			
<b>BENEFITS WILL BE PAID TO:</b>			
(1)			
(2)			
<b>PRINCIPAL B/DR</b>			
(1)			
(2)			
<b>9. I HAVE READ AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM. I ALSO UNDERSTAND THAT:</b> <ul style="list-style-type: none"> <li><i>This form cancels any prior beneficiary/designated recipient or payment instructions.</i></li> <li><i>The proceeds will be paid to B/DR(s) as stated in Paragraph 2 of the instructions, unless otherwise stated above.</i></li> <li><i>If I have legal questions about this form, I may consult with a military attorney at no expense to me.</i></li> <li><i>Maximum coverage amount available as of this date is \$ _____. Your initials: _____</i></li> </ul>			
<b>a. YOUR SIGNATURE</b> ( <i>Sign in ink. Do not print.</i> )			<b>b. DATE</b>
<b>10. (Do not write in space below - for official use only.)</b>			
<b>a. WITNESSED AND RECEIVED BY</b>	<b>b. RANK, TITLE, OR GRADE</b>	<b>c. ORGANIZATION</b>	<b>d. DATE RECEIVED</b>



# READY RESERVE MOBILIZATION INCOME INSURANCE CERTIFICATE

(Please read the Privacy Act Statement and Instructions before completing this form.)

## 1. USE THIS FORM TO: (X all that apply)

- ☐ a. Name, change or update your beneficiary  
☐ b. Increase the amount of your insurance coverage  
☐ c. Reduce the amount of your insurance coverage  
☐ d. Decline insurance coverage (IRREVOCABLE)

**IMPORTANT:** This form is for use by members of the Ready Reserve. This form does not apply to and cannot be used for any other Government Insurance.

2. NAME (Last) (First) (Middle)

3. RANK, TITLE, OR GRADE

4. SOCIAL SECURITY NUMBER

5. BRANCH OF SERVICE (Do not abbreviate)

6. CURRENT DUTY LOCATION

## 7. AMOUNT OF INSURANCE

By law, you are eligible for the basic benefit of \$1,000. If you want \$1,000 of insurance, skip to Item 8, "Beneficiary(ies)/ Designated Recipient (B/DR) and Payment Options." If you want less than \$1,000 of insurance, please mark (X) block a. below and write the amount desired and your initials. Coverage is available in the following amounts: \$500, \$1,000, \$1,500, \$2,000, \$2,500, \$3,000, \$3,500, \$4,000, \$4,500, or \$5,000. If you want additional coverage above the \$1,000 amount, mark block a. and write in the exact amount desired in \$500 increments up to the maximum amount allowable. If you do not want any insurance, mark block b. below and write (in your own handwriting), "I do not want insurance." Actual benefit amounts are subject to periodic adjustment.

a. I want coverage in the amount of \$ . Your initials:

b. (Write "I do not want insurance.")

**NOTE:** Once enrolled, you may reduce the amount or stop your participation at any time. However, you cannot increase your coverage. A decision to decline coverage or terminate your enrollment is generally irrevocable.

## 8. BENEFICIARY(IES)/DESIGNATED RECIPIENT (B/DR) AND PAYMENT OPTIONS

I designate the following person or entity to receive payment of my insurance proceeds. I understand that the principal B/DR(s) will receive payment upon my death. If a designation is not made, a valid claim will be payable in accordance with laws of the State of the member's domicile.

COMPLETE NAME (first, middle, last) OF EACH BENEFICIARY a.	ADDRESS (Street, Apartment No., City, State, and ZIP Code) b.	SOCIAL SECURITY NUMBER (if known) c.	RELATIONSHIP TO YOU d.	SHARE TO EACH BENEFICIARY (Use %, \$ amounts or fractions) e.
---	--	---	------------------------------	---

### BENEFITS WILL BE PAID TO:

(1)				
(2)				

### PRINCIPAL B/DR

(1)				
(2)				

## 9. I HAVE READ AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM. I ALSO UNDERSTAND THAT:

- This form cancels any prior beneficiary/designated recipient or payment instructions.
- The proceeds will be paid to B/DR(s) as stated in Paragraph 2 of the instructions, unless otherwise stated above.
- If I have legal questions about this form, I may consult with a military attorney at no expense to me.
- Maximum coverage amount available as of this date is \$ . Your initials:

a. YOUR SIGNATURE (Sign in ink. Do not print.)

b. DATE

## 10. (Do not write in space below - for official use only.)

a. WITNESSED AND RECEIVED BY	b. RANK, TITLE, OR GRADE	c. ORGANIZATION	d. DATE RECEIVED
------------------------------	--------------------------	-----------------	------------------



# READY RESERVE MOBILIZATION INCOME INSURANCE CERTIFICATE

(Please read the Privacy Act Statement and Instructions before completing this form.)

## 1. USE THIS FORM TO: (X all that apply)

- ☐ a. Name, change or update your beneficiary  
☐ b. Increase the amount of your insurance coverage  
☐ c. Reduce the amount of your insurance coverage  
☐ d. Decline insurance coverage (IRREVOCABLE)

**IMPORTANT:** This form is for use by members of the Ready Reserve. This form does not apply to and cannot be used for any other Government Insurance.

2. NAME (Last) (First) (Middle) 3. RANK, TITLE, OR GRADE 4. SOCIAL SECURITY NUMBER

5. BRANCH OF SERVICE (Do not abbreviate)

6. CURRENT DUTY LOCATION

## 7. AMOUNT OF INSURANCE

By law, you are eligible for the basic benefit of \$1,000. If you want \$1,000 of insurance, skip to Item 8, "Beneficiary(ies)/ Designated Recipient (B/DR) and Payment Options." **If you want less than \$1,000 of insurance**, please mark (X) block a. below and write the amount desired and your initials. Coverage is available in the following amounts: \$500, \$1,000, \$1,500, \$2,000, \$2,500, \$3,000, \$3,500, \$4,000, \$4,500, or \$5,000. **If you want additional coverage** above the \$1,000 amount, mark block a. and write in the exact amount desired in \$500 increments up to the maximum amount allowable. **If you do not want any insurance**, mark block b. below and write (in your own handwriting), "I do not want insurance." Actual benefit amounts are subject to periodic adjustment.

a. I want coverage in the amount of \$ \_\_\_\_\_ Your initials: \_\_\_\_\_

b. (Write "I do not want insurance.")

**NOTE:** Once enrolled, you may reduce the amount or stop your participation at any time. However, you cannot increase your coverage. A decision to decline coverage or terminate your enrollment is generally irrevocable.

## 8. BENEFICIARY(IES)/DESIGNATED RECIPIENT (B/DR) AND PAYMENT OPTIONS

I designate the following person or entity to receive payment of my insurance proceeds. I understand that the principal B/DR(s) will receive payment upon my death. If a designation is not made, a valid claim will be payable in accordance with laws of the State of the member's domicile.

COMPLETE NAME (first, middle, last) OF EACH BENEFICIARY a.	ADDRESS (Street, Apartment No., City, State, and ZIP Code) b.	SOCIAL SECURITY NUMBER (if known) c.	RELATIONSHIP TO YOU d.	SHARE TO EACH BENEFICIARY (Use %, \$ amounts or fractions) e.
<b>BENEFITS WILL BE PAID TO:</b>				
(1)				
(2)				
<b>PRINCIPAL B/DR</b>				
(1)				
(2)				

## 9. I HAVE READ AND UNDERSTAND THE INSTRUCTIONS ON THIS FORM. I ALSO UNDERSTAND THAT:

- This form cancels any prior beneficiary/designated recipient or payment instructions.
- The proceeds will be paid to B/DR(s) as stated in Paragraph 2 of the instructions, unless otherwise stated above.
- If I have legal questions about this form, I may consult with a military attorney at no expense to me.
- Maximum coverage amount available as of this date is \$ \_\_\_\_\_. Your initials: \_\_\_\_\_

a. YOUR SIGNATURE (Sign in ink. Do not print.)

b. DATE

## 10. (Do not write in space below - for official use only.)

a. WITNESSED AND RECEIVED BY	b. RANK, TITLE, OR GRADE	c. ORGANIZATION	d. DATE RECEIVED

## **DIRECTIONS TO PERSONNEL CLERKS OF THE MILITARY SERVICES**

1. Complete all appropriate items on the election form. All entries, except the signature and those requested to be in the member's own handwriting, must be typed or printed in ink. An original and at least one copy, which are the official copies, must bear an original signature of both the member and the witness.
2. Make sure the name(s) of one or more principal B/DR(s) appear in Item 8, "Beneficiary(ies)/Designated Recipient (B/DR) and Payment Options", if desired. Include the address and Social Security number, if available, for the B/DR(s) and their relationship to the member (e.g., father, sister).
3. An authorized agent of the Military Service must witness the signature of the member. This representative must sign his or her name below that of the member and should put the date he or she signed the form.
4. This form, properly executed, is authority to a payroll office to change the deductions for insurance premiums or to not make such deductions, if the amount of insurance is changed or cancelled.
5. Inform all members that if they have questions about this form that they may obtain the advice of a military attorney at no expense to the member.
6. Disposition of copies: Reproduce official copies before signing and circle distribution on bottom right of form. Wording and format of form may not be altered. Forms altered from the original wording or format are subject to acceptance by the Military Service.

Copy 1 - Must be promptly filed in the official personnel file of the member.

Copy 2 - To member. Certificate of coverage.

Copy 3 - **FOR USE BY THE RESERVE COMPONENT OF THE MILITARY SERVICES**